No. 89-1048

IN THE
# Supreme Court of the United States
OCTOBER TERM, 1989

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FMC CORPORATION,
*Petitioner,*
v.
CYNTHIA ANN HOLLIDAY,
*Respondent.*

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**On Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit**

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## BRIEF OF THE CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA, AS AMICUS CURIAE, IN SUPPORT OF FMC CORPORATION'S PETITION FOR A WRIT OF CERTIORARI

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### INTEREST OF AMICUS CURIAE [1]

The Chamber is the largest federation of business, trade, and professional organizations in the United States. It represents the interests of over 180,000 cor-

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[1] This brief is being filed with the consent of the parties, pursuant to Supreme Court Rule 37.2. The consent letters have been filed with the Clerk of the Court.

porations, partnerships and proprietorships, as well as several thousand state and local chambers of commerce and trade associations. An important function of the Chamber is to represent the interests of its member employers in important labor relations matters before this Court, the lower courts, the United States Congress, the Executive Branch and independent regulatory agencies of the federal government. Such representation constitutes a significant aspect of the Chamber's activities. Accordingly, the Chamber has sought to advance those interests by filing briefs in a wide spectrum of labor relations litigation.[2]

The question presented by the instant case—whether a state anti-subrogation law may be applied to an uninsured employee welfare benefit plan—is of great concern to all Chamber member employers that maintain and operate self-insured employee benefit plans, and that contribute to self-insured, collectively bargained, multi-employer plans. The very large number of employer members that operate and/or contribute to such plans puts the Chamber in a position to provide the Court with a more complete understanding of the certain and unending problems the Third Circuit's decision will create in the area of employee welfare benefit plan regulation.

## SUMMARY OF ARGUMENT

In considering whether a state anti-subrogation law applies to an uninsured employee welfare benefit plan governed by the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 *et seq.* ("ERISA"), the United States Court of Appeals for the Third Circuit expressly rejected this Court's view of ERISA preemption of state laws. The Court of Appeals found Pennsylvania's anti-subrogation statute applicable to uninsured plans, and in so doing, ignored a critical distinction between insured and uninsured plans that was created by Congress and expressly recognized by this Court. While this Court clearly held that ERISA preempts the application of state laws to uninsured plans, the Third Circuit decision sets the stage for dual and conflicting state and federal regulation of these plans—a result which will necessarily lead to increased administrative and benefit costs. These increased burdens are precisely the types of state-created pressures which Congress sought to avoid through preemption.

The distinction between insured and uninsured plans for ERISA preemption purposes is supported by several factors. First, when Congress chose to "save" from preemption state laws regulating insurance, it was doing no more than continuing its historical deferral to state regulation in this area. Recognizing that the insurance industry had traditionally been subject to extensive state oversight, Congress vested regulation of the insurance industry in the states through enactment of the 1945 McCarran-Ferguson Act. Ch. 20, 59 Stat. 33 (1945). By contrast, when Congress enacted ERISA in 1974, it determined that adequate safeguards concerning the operation of employee benefit plans were lacking, thus making federal regulation of those plans desirable.

Second the nature and operation of employee benefit plans make it inappropriate for them to be subject to state insurance laws designed to regulate commercial businesses and to protect consumers. While insurance companies are businesses, selling consumer products to the public, welfare benefit plans are non-profit entities which exist to provide benefits only to a sponsoring employer's employees. They do not market their products to outside groups or to the public at large.

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[2] *E.g., Trans World Airlines, Inc. v. Independent Federation of Flight Attendants*, 109 S.Ct. 1225 (1989); *Laborers Health and Welfare Trust Fund v. Advanced Lightweight Concrete Co., Inc.*, 484 U.S. 539 (1988); *Pattern Makers League v. NLRB*, 473 U.S. 95 (1985).

Third, Congress could not have accomplished its goal of eliminating the threat of conflicting and inconsistent employee benefit plan regulation without exempting uninsured plans from state regulation. Although a plan which purchases an insurance policy may rely on the insurance company to comply with any state laws affecting the company, an uninsured plan subject to state insurance laws would itself become responsible for sorting through various and conflicting state requirements.

Moreover, if upheld, the approach adopted by the Third Circuit, permitting a state law to apply to uninsured plans as long as the state law does not address "core ERISA concerns," would serve as an open invitation to the states to aggressively expand their regulation of employee benefit plans. Although ERISA, by its design, does not address many subjects, and although Congress expressly declined to extend even some of its "core" elements to employee welfare plans, this Court has recognized that the states are not free to fill in the gaps. If left unreviewed, the decision of the Court of Appeals will unleash a torrent of state legislative activity which could adversely affect millions of employees. Studies show that a large majority of welfare plans are uninsured. Increased regulation by the states will be devastating to the employers that have chosen to self-insure their plans, and will ultimately result in diminished coverage for workers and their dependents. This Court should grant the requested Writ to prevent this upheaval, and to reassert its analysis of the preemption of state laws relating to ERISA-covered plans.



## ARGUMENT

### THE WRIT SHOULD BE GRANTED BECAUSE THE THIRD CIRCUIT'S DECISION IGNORES THE COURT'S NECESSARY DISTINCTION BETWEEN INSURED AND UNINSURED PLANS—A LOGICAL DISTINCTION ROOTED IN HISTORICAL STATE REGULATION OF THE BUSINESS OF INSURANCE

This case centers on the distinction between insured and uninsured employee benefit plans. The distinction was created by Congress and reaffirmed by this Court in *Metropolitan Life Insurance Company v. Massachusetts*, 471 U.S. 724 (1985) ("*Metropolitan Life*"). Nevertheless, it was essentially ignored by the Third Circuit in the case below. In *Metropolitan Life*, this Court held that where an employee benefit plan purchases an insurance contract from an insurance carrier subject to state regulation, the plan may be subject to indirect state regulation because ERISA expressly excludes from its broad preemption provision state laws regulating insurance. 471 U.S. at 747; Section 514(b)(2)(A) of ERISA, 29 U.S.C. § 1144(b)(2)(A).[3] Where an employee benefit plan is uninsured, however, it may not be subject to state insurance laws because ERISA expressly prohibits the states from deeming an employee benefit plan to be an insurance company or in the business of insurance for purposes of a state law regulating insurance. *Metropolitan Life*, 471 U.S. at 747; Section 514(b)(2)(B) of ERISA, 29 U.S.C. § 1144(b)(2)(B).[4]

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[3] Section 514(a) of ERISA generally provides that the provisions of ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . ." Section 514(b)(2)(A), often referred to as the "savings" clause, states that except as provided in subparagraph (B), nothing in Title I of ERISA "shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." 29 U.S.C. § 1144(a), (b)(2)(A).

[4] Section 514(b)(2)(B) of ERISA, known as the "deemer" clause, states that "Neither an employee benefit plan . . . nor any

The Third Circuit rejected the Court's recognition of a clear distinction in the application of ERISA's preemption provisions to insured and uninsured plans. In holding that Pennsylvania's anti-subrogation law applies to uninsured welfare plans, the Third Circuit followed the lead of the United States Court of Appeals for the Sixth Circuit in *Northern Group Services, Inc. v. Auto Owners Insurance Co.*, 833 F.2d 85 (6th Cir. 1987), *cert. denied*, 108 S.Ct. 1754 (1988) (*"Northern Group Services"*), which upheld the application of coordination of benefits rules under a Michigan no-fault automobile insurance law to uninsured plans. Both of these Circuit Courts strained to reach a result preserving a uniform application of state laws to all employee benefit plans, "so that benefit obligations are governed by a rational system of state law and federal common law." *FMC Corp. v. Holliday*, 885 F.2d 79, 84 (3d Cir. 1989), *quoting Northern Group Services*, 833 F.2d at 89.

Yet, significant distinctions between the business of insurance and the operations of employee benefit plans motivated Congress to design a regulatory scheme under ERISA that specifically prohibited the application of state laws where true insurance is not involved. The Court should grant certiorari to prevent any further encroachment by the states, in the name of insurance regulation, on the exclusively federal area of employee benefit plans.

As an initial matter, when Congress chose to "save" from preemption state laws regulating insurance, it was doing no more than continuing its historical deferral to state regulation in this area. The insurance industry has traditionally been subject to extensive state regulation—

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trust established under such a plan, shall be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts . . . ." 29 U.S.C. § 1144(b)(2)(B).



indeed, Pennsylvania insurance legislation dates back to at least 1810. Pa. Stat. Ann. tit. 40 §§ 1 to 720, Introduction p. XXI (Purdon 1971). Congress long ago announced its intention to vest regulation of the insurance industry in the states. In 1945, Congress enacted the McCarran-Ferguson Act, Ch. 20, 59 Stat. 33 (1945), (codified as amended at 15 U.S.C. §§ 1011-1015 (1976 & Supp. V 1982)), declaring "that the continued regulation and taxation by the several states of the business of insurance is in the public interest." By contrast, Congress determined when it enacted ERISA that despite the recent growth in size, scope, and numbers of employee benefit plans, adequate safeguards concerning their operation were lacking, thus making federal regulation desirable. *See* Findings and Declaration of Policy, Section 2(a) of ERISA, 29 U.S.C. § 1001(a).

Further, allowing the states to continue to regulate insurance companies, while preventing them from regulating employee benefit plans, had a logical as well as historical basis. Insurance companies (which generally operate on a for-profit basis) are businesses, selling traditionally-regulated consumer products to unrelated customers. Insurance companies compete with each other for business, and advertise and market their products within the business community and to the public at large.

By contrast, uninsured employee welfare benefit plans are not in the business of selling consumer insurance products. They are non-profit entities which exist to provide benefits only to a sponsoring employer's employees. They do not market their wares to outside groups or to the public, and they do not attempt to broaden their base by selling coverage to unrelated beneficiaries. These distinctions more than justify Congress' refusal to permit the states to extend application of their traditional, consumer-protection insurance statutes directly to employee benefit plans.[5]

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[5] State insurance laws are commonly understood to be consumer protection statutes, regulating the sale of consumer products. *See*

Even more importantly, however, the Congressional goal of "eliminating the threat of conflicting and inconsistent State and local regulation" [6] of employee benefit plans could not have been accomplished without the comprehensive "deemer" clause. Allowing the states to regulate insurance companies did not threaten to burden employee benefit plans, even where those plans purchase insurance policies. However, Congress had to exempt uninsured plans from state regulation to ensure that the plans would not be overwhelmed by conflicting requirements.

When an employer or employee benefit plan purchases insurance from an insurance company, the plan does not itself become subject to state laws or responsible for determining the insurance company's compliance in various states. It is the insurance company's obligation to monitor the state laws that are applicable to it, and to make certain that the insurance contracts it sells are in compliance with those laws. Assumption of the administrative burden associated with differing state insurance laws is an essential component of the insurance product purchased by an employee benefit plan.

Thus, the states do not in fact regulate the employee benefit plans that purchase insurance policies. Rather, the insurance companies are regulated, and plans simply choose among the types of policies that the various states permit to be marketed.

By contrast, if the decision below is permitted to stand, and if state insurance laws are applied to uninsured em-

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Collins, *Regulation Best on State Level: Washburn*, Bus. Ins. May 2, 1988, at 69; Howard, *States to Keep Ins. Regulation*, Nat'l Underwriter, June 26, 1989, at 3; Fisher, *Agents, Consumer Groups Seek Regulatory Standards*, Nat'l Unlerwriter, June 12, 1989, at 1; Jones, *The Industry Doesn't Need a Federal 'Czar'*, Nat'l Underwriter, November 7, 1988, at 19.

[6] 120 Cong. Rec. 29197 (1974), (statement of Rep. John Dent), *quoted in Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 99 (1983).



ployee benefit plans, the plans themselves will be required to monitor and comply with extensive state regulation. This Court has already found that Congress intended ERISA's preemption provision to eliminate "[a] patchwork scheme of regulation," because the inefficiencies introduced thereby "might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them." *Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1, 11 (1987). As the Court recognized, "[p]reemption insures that the administrative practices of a benefit plan will be governed by only a single set of regulations." *Id.*

If the states are permitted to apply their insurance laws directly to employee benefit plans, those plans and their sponsoring employers will be forced to shoulder the burden of the "patchwork scheme of regulation" which Congress intended to eliminate. Further, just as this Court predicted, the costs of compliance with a multitude of state laws may force some employers to reduce benefits and discourage others from adopting plans in the first place.

There can be no doubt that administrative costs for uninsured plans will increase if those plans must comply with various state insurance laws. One of the reasons that employers and plan trustees choose to self-insure is that the administrative costs for uninsured plans are generally lower than for insured plans.[7] In addition, employers insuring their own plans can achieve savings by holding onto cash until claims are paid, instead of paying premiums in advance to an insurer.[8] Despite these sav-

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[7] Burcke, *Administrative Costs Lower Among Self Insurers: Study*, Bus. Ins., February 13, 1989, at 28, *citing* Foster Higgins, *Health Care Benefits Survey—1988*, at 24 (health care administrative expenses for self-insured employers total 5.2% of claims, while insured employers' administrative expenses total 6.6% of paid claims).

[8] Foster Higgins, *supra* note 7, at 23.

ings, however, there has been a dramatic upturn in medical plan costs.[9] Although this increase has affected both insured plans and uninsured plans, uninsured plans experienced its impact sooner.[10]

The negative financial impact of the decision below would not be limited to increased administrative costs, however. The Third Circuit analysis will also impose additional benefit costs on uninsured plans. These plans often operate with limited funds. Employers (and in the case of multiemployer plans, union and management trustees) select benefit levels and make coverage decisions in a manner designed to maximize the protection available to all plan participants. Subrogation rules and coordination of benefits provisions, like those held applicable to uninsured plans by the Third Circuit, and by the Sixth Circuit in *Northern Group Services*, 833 F.2d 85, serve to stretch an uninsured plan's limited dollars by restricting benefits to those individuals who have no other avenues of recovery. If state laws prohibit employers and plan boards of trustees from using these features of plan design, benefit costs will go up.[11]

The additional plan costs which will result directly from enforcement of the decision below could effectively

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[9] Shalowitz, *Self Insurance—Self-Funding Benefits at Peak of Popularity?*, Bus. Ins., January 30, 1989, at 3.

[10] Foster Higgins, *supra* note 7, at 22.

[11] Perhaps the only alternative to increasing benefits in response to the Third Circuit decision would be to eliminate coverage for medical costs arising out of automobile accidents. *See Liberty Mutual Insurance Group v. Iron Workers Health Fund of Eastern Michigan*, 879 F.2d 1384 (6th Cir. 1989) (coordination of benefits rules of Michigan no-fault insurance law preempted where health plan excluded coverage for automobile accidents). This completely unrealistic alternative would create a major gap in the protection of participants and beneficiaries under uninsured plans, and would raise employee morale issues which few employers and plan sponsors would consider acceptable.



eliminate the self-insurance option for employers and plans. This is precisely the type of state-created pressure Congress sought to avoid through preemption. *See Fort Halifax*, 482 U.S. at 11. The Court should take this opportunity to reaffirm the broad preemptive power of ERISA and to prevent the Third Circuit's opinion from threatening the existence of uninsured employee welfare benefit plans.

## THE WRIT SHOULD BE GRANTED AND THE THIRD CIRCUIT'S DECISION REVERSED IN ORDER TO PREVENT THE EXTENSIVE ADVERSE IMPACT OF A DECISION GRANTING THE STATES LICENSE TO REGULATE ANY AREA NOT CLASSIFIED AS A "CORE ERISA CONCERN"

The Third Circuit's disregard of the Court's careful analysis of ERISA's preemption provision, "savings" and "deemer" clauses is so fundamentally erroneous that it would require reversal even without a consideration of the impact of the decision on the employee benefit plan community. Similarly, the substantial and direct conflict among the Courts of Appeals[12] (described in full in the Petition for A Writ of Certiorari) would justify this Court's intervention regardless of the ultimate number of employers and employee benefit plans that could be affected by the issue in dispute. What gives this case even greater significance, however, is the fact that unless this Court agrees to review the decision of the Third Circuit and strikes down its faulty preemption analysis, a large number of uninsured plans covering millions of this nation's employees will be adversely impacted. In addition, unless the Third Circuit's erroneous interpretation of ERISA's "deemer" clause is overturned, the states will feel free to go far beyond anti-subrogation laws and co-

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[12] *See, e.g., Baxter v. Lynn*, 886 F.2d 182 (8th Cir. 1989) (ERISA preempts application of state subrogation law to self-insured benefit plan); *United Food & Commercial Workers v. Pacyga*, 801 F.2d 1157 (9th Cir. 1986) (same).

ordination of benefits rules, and to impose the types of extensive (and potentially conflicting) regulatory requirements which Congress expressly determined should not apply to employee welfare benefit plans.

As to the extent of the potential impact of the decision below, studies show that the majority of Americans with group health coverage are covered by plans with some aspects of self-insurance.[13] One survey indicates that the percentage of uninsured plans may be as high as 66%.[14] In addition, many large multiemployer plans self-insure.[15] The growth in self-insurance has been attributed to ever-increasing health premium costs.[16] Clearly, the self-insurance option has been viewed by many employers as a manageable alternative to the purchase of expensive insurance contracts. If the desirability of this alternative is diminished as a result of the Third Circuit decision, the result may be reduced health benefits coverage for millions of employees.

After disparaging the Court's preemption test set forth in *Metropolitan Life*, 471 U.S. at 739-747, as "[s]tating the obvious more than providing guidelines," the Third Circuit ruled that ERISA's "deemer" clause will not pre-

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[13] Donahue, *53% of Group Health Plans Are Now Self-Insured: HIAA*, Nat'l Underwriter, June 13, 1988, at 13 (based on a 1987 survey of 771 employers by the Health Insurance Association of America).

[14] The Wyatt Company, *A Survey of Health and Welfare Plans Covering Salaried Employees of U.S. Employers—1988, Group Benefits Survey—Summary Highlights*, at 32 (core employer group of 170 employers surveyed). *See also* Foster Higgins, *supra* note 7, at 23 (based on input of over 1600 employers with benefit programs covering over 10 million employees, 65% of employers with 1000 employees or more self-insure).

[15] Rappaport & Krist, *Actuarial Aspects of Self-Insured Taft-Hartley Welfare Plans: Reserves, Claim Forecasts and Setting Contribution Levels*, Empl. Ben. J., March 1986, at 14.

[16] Donahue, *supra* note 13, at 13.



vent application of a state insurance law to an uninsured employee welfare benefit plan unless the state law addresses a "core type of ERISA matter" or "core ERISA concerns." *See FMC*, 885 F.2d at 84, 88, 90. According to the Third Circuit, "core ERISA concerns" include the areas of reporting, disclosure, and nonforfeitability. *See FMC*, 885 F.2d at 88.[17] Thus, as long as a state law purporting to regulate "insurance" addresses areas other than reporting, disclosure and nonforfeitability of benefits, its provisions may be applied to uninsured employee welfare plans.

As this Court's prior decisions on ERISA preemption demonstrate, the "core ERISA concerns" approach adopted by the Third Circuit could not have been a result intended by Congress. Although ERISA imposes comprehensive requirements on employee pension benefit plans, Congress deliberately did not regulate health and welfare plans as extensively. Welfare plans were expressly excluded from the complex and finely-tuned provisions on vesting, participation, benefit accrual, minimum funding, and plan termination insurance applicable to pension plans. *See* Sections 201(1), 301(a)(1), and 4021(a)(1) of ERISA, 29 U.S.C. §§ 1051(1), 1081(a)(1), 1321(a)(1). Yet, Congress' failure to extend all aspects of ERISA regulation to welfare plans cannot be construed to give the states authority to roam. As this Court has recognized:

> Nor, given the legislative history, can § 514(a) be interpreted to pre-empt only state laws dealing with

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[17] Although the opinion is far from clear, the Third Circuit's discussion of the legislative history of ERISA's preemption provision suggests that the area of fiduciary responsibility would also be a "core ERISA concern." *See FMC*, 885 F.2d at 87-88. In addition, the Third Circuit's designation of nonforfeitability as a "core ERISA concern" suggests that other subject areas covered by ERISA, but which (like nonforfeitability) are not applicable to welfare plans, might also be considered "core" matters. *See* Section 201(1) of ERISA, 29 U.S.C. § 1051(1) (excluding employee welfare benefit plans from ERISA's nonforfeitability rules).

> the subject matters covered by ERISA—reporting, disclosure, fiduciary responsibility, and the like. The bill that became ERISA originally contained a limited pre-emption clause, applicable only to state laws relating to the specific subjects covered by ERISA. The Conference Committee rejected these provisions in favor of the present language and indicated that the section's pre-emptive scope was as broad as its language.

*Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98 (1983).

It was the broad scope of ERISA preemption that the Court focused on in *Metropolitan Life* when it held that mandated benefit laws do not apply to uninsured plans, even where they are drafted as state insurance laws "saved" from ERISA preemption. Mandated benefit laws generally do not address the areas of reporting, disclosure, or nonforfeitability, and, indeed, go far beyond any ERISA requirement applicable either to welfare or pension plans.[18] Would the Third Circuit analysis lead to the conclusion that mandated benefit laws thus do not address "core ERISA concerns"? If so, even the state law discussed by this Court in *Metropolitan Life* could be found not to be preempted by ERISA.

Even more disturbing is that in rushing to its desired judgment, the Third Circuit failed to recognize that a state anti-subrogation law in fact addresses the "core ERISA concern" of nonforfeitability. The Pennsylvania antisubrogation law at issue in this case prohibits any right of subrogation or reimbursement from a participant's tort recovery with respect to medical claims paid. *See* 75 Pa. Cons. Stat. Ann. § 1720 (Purdon 1984). It essentially requires plans to treat a health benefit as "vested"—immune from certain reimbursement claims by

[18] ERISA leaves the question of which benefits will be provided under a plan to the private parties creating it. *See Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 511 (1981).



the plan, and, therefore, nonforfeitable.[19] Even if the Third Circuit's approach could be sustained under the reasoning of this Court's prior decisions, the proper analysis would lead to the preemption of Pennsylvania's anti-subrogation law on the ground that it improperly requires vesting of welfare plan benefits. That the Third Circuit did not even address this point demonstrates the danger in allowing to let stand a preemption test that would give wide latitude to the states and the lower courts in determining what is central to ERISA and what is not.

If left undisturbed, the Third Circuit decision will serve as an open invitation to expansive state regulation of employee welfare plans. Indeed, it would be difficult to predict the ingenuity which the states could apply in devising creative new requirements for plan regulation which could fit within the Third Circuit analysis. One can assume, however, that various (and conflicting) anti-subrogation rules and coordination of benefit laws will be imposed throughout the states, along with rules relating to benefits processing and the timeliness of payment of claims.[20] The states may also attempt to impose

[19] *Cf. Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (New Jersey law prohibiting offset of pensioner's workers' compensation benefits against his pension is preempted by ERISA; although offset would ordinarily constitute impermissible forfeiture under ERISA, it is specifically permitted under lawful regulations of Internal Revenue Code). Congress, of course, expressly declined to extend ERISA's vesting requirement to health and welfare benefits. *See In Re: White Farm Equipment Co.*, 788 F.2d 1186 (6th Cir. 1986) (no absolute rule requiring mandatory vesting of retiree medical benefits; Congress expressly exempted welfare plans from stringent vesting, participation and funding requirements). *See also Metropolitan Life*, 471 U.S. at 732 (ERISA does not regulate substantive content of welfare benefit plans), *citing Shaw v. Delta Air Lines, Inc.*, 463 U.S. at 91.

[20] *See, e.g.*, Ill. Ann. Stats., Chap. 73 §§ 964, 969 (Smith-Hurd 1988); Ohio Rev. Code Ann. § 3901.38 (Anderson 1989); Tenn. Code Ann. § 68-11-219 (1988).

minimum asset (actuarial reserve) requirements and other traditional "insurance" obligations on uninsured plans.[21] Uninsured plans covering participants in more than one state will be thrust into the state law compliance business, forced to sort through new and conflicting requirements, all in contravention of the federally-designed scheme of uniform employee benefit plan regulation.

Accordingly, Amicus Curiae urges this Court to grant the Writ to resolve the irreconcilable differences between the Third Circuit's treatment of the case below and the contrary views expressed by this Court, Congress, and the other Courts of Appeals which have addressed this issue; and to prevent the certain adverse impact on welfare plans which will result from this unwarranted expansion of state regulation.

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[21] *See, e.g.*, Pa. Stat. Ann. tit. 40 § 93 (Purdon 1971).



## CONCLUSION

The potential impact of the Third Circuit's decision demonstrates why this Court should once again address the scope of ERISA's preemption provisions. If left undisturbed, the decision below will disrupt ERISA's carefully-constructed scheme of uniform federal regulation, and will threaten the viability of the nation's uninsured welfare benefit plans. This Court should grant the Writ to remove that threat.

For the foregoing reasons, Amicus Curiae, the Chamber of Commerce of the United States, urges that the petition of FMC Corporation be granted.

Respectfully submitted,

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